State Medicaid Health Information Technology Plan

September 10, 2014

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Change Control Log

Previous Submission Section	Current Submission Update Description	Submission Date
Sections 1 and 2	The two sections were combined into Section 1 – Summary and re-written.	09/10/2014
Section 3	Updated to Section 2 with a complete re-write.	09/10/2014
Section 4	Updated to Section 3 with a complete re-write.	09/10/2014
Section 5	Updated to Section 4 with a complete re-write.	09/10/2014
Section 6	Updated to Section 5 with a complete re-write.	09/10/2014
Appendix A	Updated with additional acronyms	09/10/2014
Appendices C – M	Removed as the necessary information was summarized and incorporated in Sections 1 – 6.	09/10/2014

1 Summary

The State of Nebraska's Department of Health and Human Services (DHHS) recognizes that the long-term future vision for Health Information Technology (HIT) involves the effective exchange and use of information to track and improve health outcomes while reducing the long-term spend on healthcare. Specifically, this vision includes the sharing of necessary patient information at the point of care through standardized health information exchange between providers to offer enhanced information for diagnosis and treatment decisions. Achieving this long-term goal requires a cultural change within the healthcare community. This change requires the participation of various stakeholders including providers, health insurers, public health, government, etc.

DHHS understands that the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) System Incentive Payment Program for its Medicaid eligible professionals (EPs) and eligible hospitals (EHs) (collectively Providers) was implemented to more rapidly increase the adoption rate by providers for the meaningful use of Health Information Technology (HIT) as required by the American Recovery and Reinvestment Act of 2009 (ARRA). DHHS in furtherance of these goals views its role as supporting the following activities:

- Administer the Medicaid EHR Incentive Program for Nebraska, hereafter referred to as MIP, pursuant to the program rules.
- Provide MIP oversight.
- Promote the adoption and meaningful use of HIT and exchange of health information.

During the inception of MIP, DHHS undertook a rigorous planning process designed to consider and incorporate all of the requirements for a successful implementation of its HIT initiatives that included payment of the incentives for adopting, implementing, or upgrading to certified EHR systems and Meaningful Use of EHR technology for Nebraska Medicaid Providers. Since that time, DHHS has continued to carefully consider the current technology, business and operational environment and continued planning for the necessary changes to administer MIP, conduct oversight activities, and promote adoption within Nebraska. Most significantly, DHHS is implementing a new system supporting the administration and oversight of MIP.

Based on the important changes since the initial SMHP, DHHS determined it most appropriate to re-draft the SMHP to reflect the current implemented program. The SMHP contains the following sections:

- Section 1 - Summary
- Section 2 - As-Is HIT Landscape
- Section 3 – To-Be HIT Landscape
- Section 4 – Roadmap

- Section 5 – MIP Program Implementation, Administration, and Oversight Strategy
- Appendices

2 As-Is HIT Landscape

From October 2010 through March 2011, DHHS conducted an environmental assessment to evaluate Nebraska's current HIT landscape. The assessment included the following factors:

- Stakeholder Assessment (providers, health insurance exchange, state, etc.)
- Legal and Regulatory Support for EHR Adoption
- Broadband Capability
- Consumer View and Acceptance

While a new detailed environmental scan has not been conducted, this section of the SMHP has been updated to include the currently available information.

2.1 Stakeholder Assessment

The Statewide Health IT Coordinator for Nebraska is fostering an environment of joint participation and collaboration between the HIT stakeholders in Nebraska. The status and activities related to the various stakeholders are contained within this section.

2.1.1 Eligible Provider EHR Adoption

During the initial environmental assessment, DHHS worked with provider associations and Wide River TEC, the Nebraska REC to understand the status of EHR provider readiness and adoption. DHHS reviewed results of existing surveys conducted by HIT stakeholders. The dates of these surveys ranged from 2007 to 2011 and provided historical context on adoption of providers by different provider type.

DHHS conducted the most recent survey in 2011of eligible providers (EPs) and eligible hospitals (EHs). DHHS designed the survey to collect information regarding the level of EHR adoption, provider education and training needs, barriers to adoption, and intention to apply for the Medicaid Incentive Program (MIP).

The majority (92 percent) of survey respondents were Medicaid enrolled professionals. Most respondents were located in an urban setting (64 percent). Physicians and dentists had the largest representation in the survey. EP respondents primarily specialized in general family practice and worked in a group or partnership medical or dental practice facility.

When comparing EHR adoption and HIE and MIP participation, minimum variances across Provider types existed. However, physicians appeared to have a lower response rate of "unsure" when asked about these topic areas. The survey findings indicated that dentists have the largest variance from other professionals. EHR adoption rates were less than half that of other professionals and about 65 percent were unsure about future EHR purchases.

Close to half of all respondents had an EHR system in place. The professionals practicing in an urban setting (52 percent) had a slightly higher adoption rate over those in rural practices (42 percent). About half of those with an EHR system, 18 percent of all respondents, indicated the EHR was certified. By 2015, 37 percent of all EPs that responded anticipated having a certified EHR system in place.

The detailed historical data contained within these surveys is not presented in this document as the data is no longer representative of the current status of provider readiness and adoption of EHR. The original data was included in the initial SMHP and is available upon request.

While a new survey has not been completed since 2011, a recent assessment with the providers who attested to AIU and have not yet attested to MU show barriers include availability of EHR vendors to support the implementations and providers who have existing EHR systems that are not yet certified to the 2014 Edition.

Current participation in the MIP is available and indicates that EHR adoption is increasing within the state of Nebraska. In 2011, Nebraska had anticipated 600 providers would qualify during the life of the program. In the first program year, 484 EPs qualified for a Medicaid incentive payment. 54% of the EPs have returned for a second year payment in 2013. The current statistics show over $14 million has been paid and 596 unique EPs are participating in the MIP.

2.1.2 Eligible Hospital EHR Adoption

DHHS also conducted a survey to determine eligible hospital readiness as part of the environmental assessment in 2011. 66 out of the 90 hospitals in the State completed most of the questions. Three Behavioral Health Regional Centers, one Veterans Administration (VA) center, and one Indian Health Service (IHS) hospital did not receive the survey. These institutions are discussed in sub-sections 2.1.5, 2.1.6, and 2.1.12.

Most of the hospitals (95.5 percent) that responded to the survey were Medicaid enrolled Providers. Critical access hospitals (CAHs) accounted for the majority of the hospital type respondents (67.2 percent), with the second largest being noncritical access hospitals (non-CAHs) (22.4 percent). Approximately 74 percent of the hospitals that participated in the survey were located in rural areas and 26 percent were located in urban areas.

Close to 60 percent of all the hospitals that participated in the survey had an EHR system in place. Significant differences were noted between rural and urban area adoption. The majority of urban hospital survey respondents (88 percent) had an EHR system in place compared to about half of the rural hospitals surveyed (47 percent). Approximately 33 percent of respondents indicated that their EHR system was certified, but nearly 90 percent indicated that they expected to have a certified EHR by 2013.

As indicated in Section 2.1, a new survey has not been completed since 2011. However, current information available indicates that EHR adoption is increasing within the state of Nebraska. Of the 90 hospitals in NE, only six are not currently participating in either the Medicare or MIP. Eleven dually-eligible hospitals are currently only participating in the Medicare EHR Incentive Program mostly due to not meeting the 10% Medicaid patient volume. 76% of those who received a Medicaid EHR Incentive payment in 2012 have returned for a 2013 payment.

2.1.3 FQHCs/RHCs

There are 13 FQHCs and 122 RHCs located in Nebraska and enrolled with Nebraska Medicaid. FQHCs and RHCs are already working together and exchanging health care information. Three initiatives in Nebraska received funding from HRSA to support Provider adoption of HIT and HIE.

One World Health Centers, acting as the fiscal agent for the Heartland Community Health Network and as a member of this network, was awarded $1,511,083 from the ARRA Health Information Technology Implementation Grants. Heartland Community Health Network is a collaborative network of the following five FQHCs:

- One World Health Centers, NE
- Charles Drew Health Center, NE
- People's Health Center, NE
- Norfolk Community Health Clinic, NE
- Council Bluffs Community Health Center, IA

Heartland has applied this funding to assist by providing technical support in the adoption of HIT and HIE. Specifically, Heartland has utilized this funding to customize the NextGen EHR to make it more usable in a community health center setting and to lead performance improvement activities across all five health centers.

WNHIE included Panhandle Community Services Health Center, the FQHC serving this region, in its HIT adoption and HIE planning initiative. WNHIE received several grants including: 1) a planning grant from the United States Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) in 2004; 2) a three-year implementation grant from AHRQ; 3) a HRSA Rural Network Development Grant, a Rural Health Care Pilot grant from the Federal Communications Commission; and 4) a grant from the Nebraska Information Technology Commission. The primary goal for this collaborative effort was to lay the foundation for connectivity and health information exchange for the participating Providers in this region was met. WNHIE decided to utilize their existing HIT and human capital resources to provide HIT training sessions and through a partnership with Western NE Community College has offered HIT training for college credit.

In September 2007, Thayer County received $1.6 million in funds from the ORHP Medicare Rural Hospital Flexibility CAH HIT Network Implementation Program. The goal of this program was to support the implementation of HIT systems in CAHs and their associated network of Providers by allowing the grantee to use the funding in a flexible way. TCHS used this award to establish the State's first HIE –SENHIE. Five RHC satellite clinics located in Bruning, Chester, Davenport, Deshler, and Milligan participated in this project.

2.1.4 HIT Regional Extension Center (REC) Status

As of August 24, 2012, of the 1,065 primary care providers who worked with Wide River TEC, 806 installed an EHR and are using it to report quality measures and e-prescribe, as of August 24, 2012. Of the 54 critical access hospitals working with Wide River TEC, 27 have implemented an EHR. REC grant funding ended in February of 2014.

2.1.5 Indian Health Service (IHS)

Health care services are available to Nebraska Native Americans at IHS and tribal facilities. Winnebago Indian Hospital is an IHS facility, whereas Carl T. Curtis Health Center, Fred LeRoy Health and Wellness Center, Santee Sioux Clinic, and Winnebago Tribal Health Department are tribal-based facilities.

Since both the Nebraska IHS and the tribal health facilities subscribe to the Aberdeen Indian Health Service Area Office for HIT oversight, they all subscribe to the national IHS EHR system Resource and Patient Management System. This factor has enabled Nebraska's IHS facilities to progress in adoption and meaningful use as the nationwide IHS EHR system has undergone enhancements.

In addition to the IHS and tribal healthcare facilities, the Nebraska Urban Indian Coalition also provides services to this population. The Lincoln and Omaha sites in Nebraska and the Sioux City site in Iowa provide services to Native Americans that do not reside on a reservation. The Omaha behavioral health site and Lincoln medical clinic have implemented the EMRs.

2.1.6 Department of Defense / Veterans Administration

Offutt Air Force Base is the only active military installation in Nebraska with a medical facility. The Ehrling Bergquist Clinic at the base provides comprehensive outpatient care, as well as pharmacy, lab, and radiology services. There is an electronic exchange of military health information to civilian-based Providers.

There are approximately 150,000 Veterans in the State of Nebraska who receive health care services from the Veterans Administration Nebraska-Western Iowa Health Care System (VA NWIHCS). Provider members of the VA NWIHCS include the VA Medical Center in Omaha, the Community Living Center in Grand Island and seven community-based outpatient clinics.

The VA NWIHCS uses the Veterans Health Information Systems and Technology Architecture (VistA) EHR system. This technology is used to share patient information among VA facilities only. VistA is a Web-based tool that allows Providers to securely sign in and access patient health records from remote locations. While patient information is typically not electronically shared outside of the Nebraska VA system, there is the capacity for patient information exchanges on a case-by-case basis when the Interconnection Security Agreement is signed.

2.1.7 Nebraska Health Information Initiative (NeHII)

NeHII began as a public and private collaborative initiative between the Nebraska Chamber of Commerce and University of Nebraska in 2005 with the intent of realizing job creation through economic development opportunities created by using innovative technologies to reform the delivery of health care. The goal of this joint effort was to create a common health record for use by all participants across the State. NeHII was designated as the statewide integrator by Governor Heineman in June 2009.

NeHII's governance structure is a public / private sector led with government collaboration. The State's Department of Administrative Services acted as the recipient and fiscal agent for the State HIE Cooperative Agreement. NeHII, as the designated statewide integrator for Nebraska, was responsible for the implementation and management of the Statewide HIE. NeHII, Nebraska Information Technology Commission (NITC) eHealth Council, and the State HIT Coordinator work together to facilitate HIE exchange initiatives throughout the State.

NeHII collaborates with Iowa, Kansas, Colorado, South Dakota, and Wyoming regarding cross border HIE activities. While NeHII encourage participation from border state providers, participation is by choice. In addition to providing HIE services across state borders, NeHII provides business plan development, helpdesk functions, and training services to out-of-state Providers or state HIEs that can use NeHII's expertise.

The SMA and Public Health both hold seats on NeHII's board and are members of the NITC eHealth Council.

As of August 1, 2014, 2,781,458 patient records are contained within NeHII and 2,296 healthcare practitioners participate with NeHII. NeHII has the current infrastructure in place to support:

- Virtual Health Record (VHR)
    - Provides a comprehensive electronic health record (EHR) accessible with a single click by an authorized healthcare provider.
    - Retrieves and displays data from across the entire Health Information Exchange (HIE). All available patient data is pulled together virtually to create a complete electronic health record.

- Includes patients' laboratory, radiology, reports, including history and physicals, consults, discharge summaries, visit records, medication history, problem lists, allergies, up-to-date eligibility information, and exams ordered by clinicians, and any encounter notes and referrals.

- Electronic Medical Record (EMR)
  - Provides the ability to quickly and effectively collaborate with any of the patient's caregivers, sharing data and processing referrals electronically.
  - Connects physicians to the NeHII Health Information Exchange, giving the ability to receive ARRA stimulus monies and improve care for patients.
- e-Prescribing
  - Provides significant efficiencies to practices and meets Meaningful Use requirements for ARRA stimulus compensation.
  - Ensures the most accurate medication, problem, and patient information from NeHII for safe prescribing. Prescribers have the ability to view patients' eligibility, prescription history, formularies, and generic and therapeutic alternatives, which are displayed when prescribing. Prescriptions are automatically checked for dangerous interactions and allergies and are delivered to the patient's pharmacy. Refills are approved with a few clicks from any computer.
- Interoperability HUB/Physician Connection
  - Builds a direct network from disparate certified EMRs and legacy systems enabling complete interoperability and full collaboration on patient care.
  - Gives physician practices the ability to immediately exchange data such as referrals, and can also provide specific data for query by community-wide physicians; providing the entire community, regional, state or national HIEs with a complete picture of health for a patient.
- Direct
  - Enables a healthcare provider to electronically and securely push specific health information, such as discharge summaries, clinical summaries from a primary care provider or specialist, lab results to ordering providers, or referrals over the internet to another healthcare provider(s) who is a known and trusted recipient.
  - Allows for the transmission of health information in a uni-directional flow using a secure, standard, scalable, encrypted format and ensures that the information goes to the correct provider or organization.

2.1.8 Electronic Behavioral Health Information Network (eBHIN) / Heartland Community Health Network (HCHN)

Electronic Behavioral Health Information Network (eBHIN), was a behavioral health specific HIE. eBHIN's goal was to provide HIE services, as well as EMR, billing, and practice management

modules to contracted Providers. eBHIN started in the State of Nebraska Division of Behavioral Health (DBH) region V. eBHIN is dissolving due to financial unsustainability. Effective September 1, 2014 eBHIN will transition management of core services to HCHN. HCHN has been operating the eBHIN applications since June of 2011 and will become directly responsible for the delivery of technology services.

2.1.9 eHealth Council

The eHealth Council was created by the NITC on February 22, 2007. The eHealth Council was created to facilitate discussions among eHealth initiatives in the state and to make recommendations to the NITC regarding the adoption and interoperability of eHealth technologies.

The eHealth Council has overseen the completion of the State's eHealth Strategic and Operational Plans. These plans, approved by the Office of the National Coordinator for Health Information Technology (ONC) in November of 2010, supported the execution of the State HIE Cooperative Agreement. Funds from the State HIE Cooperative Agreement award have been used to accelerate HIE development Statewide.

2.1.10 DHHS – Division of Public Health

The State of Nebraska Division of Public Health (DPH) is made up of 20 local health departments. The DPH provides oversight of preventive and community health programs and services. In furtherance of this responsibility, the DPH also maintains multiple registries of health information including:

- The Nebraska State Immunization Information System (NESIIS) - The Nebraska State Immunization Information System (NESIIS) is a secure, statewide, web-based system that's been developed to connect and share immunization information among public clinics, private provider offices, local health departments, schools, hospitals and other health care facilities that administer and track immunizations in the State of Nebraska. The primary function of NESIIS is to collect data so that Providers may track and identify required immunizations. For facilities without an electronic health record (EHR) system, NESIIS offers a user-friendly manual interface that allows a facility to enter, view and track immunizations that have been given, manage vaccine inventory, forecast vaccinations needed, and run reports and reminder-recall notices. For facilities with an EHR, NESIIS is capable of uni-directional and bi-directional electronic data exchange using the HL7 2.5.1 format to minimize the amount of manual data entry or double data entry for facilities. A connection has been established with NeHII, but provider adoption is slow as the majority still use point to point connectivity with DPH.
- Epidemiological Surveillance - DPH utilizes the National Electronic Disease Surveillance System (NEDSS) to track disease patterns and coordinate responses to outbreaks in the State of Nebraska. NEDSS is a secure web-based program that allows healthcare professionals and government agencies to communicate, plan,

and respond to such events in a timely manner. The CDC is in charge of maintaining and expanding NEDSS so that the speed, accuracy, standardization and viability of data about diseases are improved. The goal of this surveillance program is to identify trends in reportable diseases and support local health departments' outreach efforts.

- Syndromic Surveillance - To expand the scope of syndromic surveillance, strengthen current surveillance capabilities, and improve the effective practice of public health in Nebraska, DPH created the Syndromic Surveillance Event Detection of Nebraska (SSEDON). The objective of this syndromic surveillance program is to detect, track and analyze disease events to establish at-risk populations, develop effective prevention plans, monitor trends in morbidity and ultimately improve population health through better, more-timely, disease surveillance. SSEDON accepts HL7 2.5.1 formatted health information electronically through PHINMS. Currently, no connection exists with NeHII for exchange of this information. However, DPH and NeHII are in discussions to identify a pilot site. Funding for this functionality has been requested through an Implementation Advanced Planning Document (IAPD).

2.1.11 DHHS –Division of Medicaid & Long-Term Care (MLTC)

Nebraska's State HIT Coordinator is the Lieutenant Governor. The HIT Coordinator works closely with the eHealth Council in facilitating HIE activities across the State. The SMA holds a seat on eHealth Council and the statewide health information exchange, NeHII. Participation by both the State HIT Coordinator and DHHS to promote Statewide Provider adoption and Meaningful Use of EHRs will ensure ongoing coordination of State resources.

MLTC is currently conducting a MITA 3.0 state self-assessment including assessing the as-is business processes associated with MIP. MLTC is implementing a new solution to improve customer service and operational efficiency with the MIP program. Please refer to section 5 of the plan for information related to MIP program administration. MLTC is currently in the planning process to modernize the MMIS to advance in business information, and technical architecture maturity.

2.1.12 DHHS – Division of Behavioral Health (DBH)

The DBH central office is located in Lincoln. DBH is made up of the Community-Based Services Section and the Regional System Section.

Community-Based Services is organized into six local behavioral health regions that receive funding, oversight, and technical support from DBH. The regions contract with local programs to provide public inpatient, outpatient and emergency services and community mental health and substance abuse. These contracted Providers are responsible for maintaining their own medical records, whether they are in paper or electronic format.

There is no centralized EHR system, clinical data repository, or exchange of patient health information. However, Magellan Behavioral Health Services is contracted with Community-Based Services to pay claims, perform authorizations, and collect outcome measures. Therefore, Magellan collects patient demographic and some health related information to carry out these functions. Magellan interfaces with the MMIS system for the purpose of eligibility and prior authorization determination.

Magellan provides reports and data extracts in PDF and Excel format to Community-Based Services who then share them with the local regional agencies and contracted Providers. Contracted Providers also may access standard PDF reports specific to their agency on the Magellan Website. Community-Based Services also uses Magellan to report Treatment Episode Data Set and State Outcome Measurement and Monitoring System to federal agencies as required.

The DBH Regional System Section is comprised of three Regional Centers, located in Lincoln, Norfolk and Hastings. The Regional Centers are responsible for providing services to patients committed by mental health boards or the courts. All three Regional Centers currently use Netsmart's Avatar EMR system. Each Regional Center has its own server, and therefore, does not share patient data across entities. There is no external exchange of patient information or immediate plans to join NeHII or eBHIN. They have recently awarded a contract to Orion Healthcare Technology to develop a BH centralized data system that will replace Avatar.

2.1.13 DHHS Information Systems and Technology (IS&T)

IS&T is the technology agency within DHHS that supports the majority of the critical solutions supporting DHHS. The two systems predominantly supporting the majority of functions are the MMIS and N-FOCUS. The MMIS supports claims payment along with the required ancillary functions. N-FOCUS currently supports eligibility and intake for Nebraska Medicaid as well as other programs. However, DHHS is currently in the process of implementing a new eligibility and enrollment system which will replace this functionality. While the systems internally exchange necessary administrative information, neither of these systems are connected for exchange of health information at this time. As referenced above, significant planning is taking place to modernize Nebraska Medicaid's technology footprint.

2.2 Legal and Regulatory Assessment

During the initial assessment, DHHS conducted a comprehensive review of the Nebraska Medicaid regulations (Titles 471, 480 and 482), the Nebraska Medicaid Program State Plan (State Plan), and Nebraska Department of Health and Human Services (DHHS) Health Insurance Portability and Accountability Act (HIPAA) privacy and security policies and internal memoranda. This review concluded that while opportunities for clarification were available, the Nebraska Medicaid regulations were not in conflict with HIPAA or HITECH.

2.3 Broadband Internet Access

As found in many states, Nebraska has greater broadband penetration in urban areas than in rural areas of the State. A visual representation of coverage may be found on the National Broadband Map (http://www.broadbandmap.gov/technology), an initiative detailed below. Despite varying levels of geographic coverage, availability to broadband connectivity does not seem to be at issue for health care providers as demonstrated in the survey results from the original assessment.

2.4 Consumer View

In November 2008, the University of Nebraska Public Policy Center conducted a project to research the views of the State of Nebraska's citizens on HIT and electronic sharing of health information. The survey was completed by 168 Nebraskans, 34 of which also participated in a more focused discussion. The findings of this effort suggest that consumers are generally receptive toward HIT and the exchange of patient health information. While perceptions of health technology were positive, some consumers expressed concerns regarding privacy and security.

The results of this research indicate that most participants believed that State government should play a role in ensuring the privacy and security of health information (100 percent), providing information to consumers about health information security and privacy (94 percent), regulating health information networks (91 percent), and facilitating public-private partnerships to exchange health information (88 percent). Findings also reveal that consumers would like to see State government play a role in consumer education and 72 percent of the deliberation participants said it was "very important" for the State government to educate Nebraskans about electronic HIE.

Additionally, Nebraska residents reported that they regularly use the Internet to access health or insurance information. Although consumers would like to, many do not use the Internet to communicate directly with their Providers through email. A new survey has not been conducted since the original survey was performed in 2008.

Nebraska residents also receive services in Border States. Based on the State of Nebraska's Medicaid claims data, approximately 10 percent of Nebraska's Medicaid beneficiaries receive care out of the State.

3 To-Be HIT Landscape

Nebraska has chosen a public / private sector driven model where the private sector marketplace is propelling the advancement and sustainability of health information exchange to support the long-term future vision for HIT. This vision involves widespread effective exchange and use of information to improve the quality of health outcomes while reducing the long-term spending on healthcare. However, achieving the long-term vision within the next five years is not feasible. DHHS' reasonable expectation is to progress steadily toward the above long-term goal. During the next five years, DHHS' goals are to:

- Improve the efficiency of the administration of MIP.
- Pursue initiatives that encourage the adoption of certified EHR technology.
- Promote meaningful use of HIT, health care quality, and the exchange of health information.
- Support the geographical and functional expansion of health information exchange capabilities.

The To-Be HIT Landscape section of this plan includes the long-term vision as well as the activities that DHHS will take in the next five years to progress in addressing these goals.

3.1 Future Vision for DHHS

DHHS is made up of several divisions. This section addresses the efforts of the Division of Medicaid and Long Term Care (MLTC) and the Division of Public Health (DPH). Both divisions under DHHS have been and will continue to work in a collaborative manner regarding the advancement of HIT. The long-term vision for DHHS includes electronic submission of necessary information, utilizing standardized interfaces, by providers to DHHS to better enable DHHS to:

1. Monitor the quality of care being provided.
2. Provide actionable relevant information to DHHS care management and managed care entities to enable the identification of at risk patients who would benefit from care management activities.
3. Monitor adherence to plans of care developed by care management entities.
4. Inform public health officials as expediently as possible of potential health out-breaks impacting specific demographic regions or populations in the state.

DHHS participates with partners such as the NITC eHealth Council's Public Health Work Group to identify ways to utilize health information exchange to enhance disease surveillance and other public health efforts. Efforts such as these have clearly identified the business need. However, in most cases, the effectiveness is limited based on HIT adoption and health information exchange capabilities. Therefore DHHS' focus for the next five years is primarily on HIT adoption and improved HIE capabilities as these are necessary to enable DHHS to fulfill its long-term vision.

3.2 Future Vision for Providers

The long-term vision includes supporting providers to utilize certified EHR technology and exchange patient information regardless of the point of care service. Reaching this vision is particularly challenging due to the rural nature of Nebraska. Nebraska's relatively small population is spread over 77,421 square miles, giving Nebraska an average population density of 23 persons per square mile. Delivering the information exchange capabilities necessary to support this vision in an affordable manner in rural areas has required a strategic approach. Nebraskans have responded to the challenges of providing services to a relatively small population over a large geographic area by leveraging existing resources, facilitating cooperation among various entities in the state, and by carefully allocating financial resources. In fact, there are 13 FQHCs and 122 RHCs located in Nebraska and enrolled with Nebraska Medicaid. FQHCs and RHCs serve a high volume of Medicaid clients. The FQHCs and RHCs are currently working together and already exchanging health care information. As DHHS and its Providers move forward with the future vision, DHHS will continue to incorporate clinical quality data elements as part of program initiatives and evaluations.

While Nebraska has chosen a public / private sector model for health information exchange, DHHS recognizes that Medicaid needs to support its allocated share of the responsibility to ensure functionality is available for providers. These capabilities are central to DHHS' long-term vision. Therefore, DHHS has recently submitted an Implementation Advanced Planning Document (IAPD) to fund the Medicaid portion of these capabilities. More information regarding these capabilities is described in the technical vision section of this document.

DHHS has provided extensive informational resources for providers at the DHHS web-site. Additionally DHHS is currently implementing a new MIP solution, as described in Section 4, to enable a more efficient process for providers to report information and obtain incentive payments. Nebraska conducted a survey of the HIT and HIE environments to help define the future vision for health technology in the State of Nebraska. DHHS is coordinating with the NeHII on the Provider communication and education process to create efficiencies in communication and consistent messaging.

3.3 Technical Vision

Encouraging provider adoption and meaningful use of certified EHR technology is beneficial. However, the individual systems being used by providers must be connected to enable health information exchange between provider organizations. Nebraska has chosen NeHII as the statewide health information exchange to support these capabilities. eBHIN was previously selected to provide capabilities for behavioral health exchange, but as referenced in Section 2, eBHIN was not able to accomplish a financially sustainable model. The future advancement of behavioral health information exchange will need to be re-evaluated within the state and is unclear at this time.

3.3.1 Statewide Health Information Exchange

The ability to connect the disparate provider systems throughout the state is key to accomplishing the long-term vision and a significant portion of the value equation for HIT. The State of Nebraska Strategic Plan includes integration of local HIEs with the Statewide HIE, NeHII. The Strategic Plan includes a vision of information exchange between DHHS and State-based programs using NeHII as a central point of integration. As of August 24, 2014, NeHII supports more than 1600 providers and 20 of Nebraska's 90 hospitals. The vision for the statewide exchange is that the vast majority of providers will have an EHR connected and communicating bi-directionally to the Exchange. NeHII has a list of pending hospitals that are currently progressing toward connection. However, significant effort is necessary to connect and normalize data from each provider and hospital for the Exchange, even when utilizing standard transaction formats, due to unique data definitions for each provider.

NeHII provides the foundational functionality for statewide HIE including:

- ***Master Patient Index and Record Location***: The databases and tools to find patient-related data across multiple sources, reliably retrieve information, and present a patient's complete electronic health record. This component also includes the ability to store and update patient consent preferences, information access, and disclosure.
- ***Provider Directory***: A directory of providers connected to and authorized to use NeHII's HIE network. The Provider Directory also includes the ability to manage the entry, authentication, and authorization of users and entities, and participants' access privileges.
- ***Integration Services***: Provides message composition, parsing, sending, and receiving, routing and mapping.
- ***Interoperability Services***: The ability to present and transport data in a standard manner. The interoperability services are a collection of web services that provide advanced mechanisms for exchanging clinical data among systems.
- ***Mobile Messaging Services***: Mobile clinical messaging provides the ability to send an automated text message and/or email to a designated provider for a specified patient population based on defined Admission, Transfer, Discharge (ADT) transactions.

The largest challenge facing Nebraska is increasing the adoption of HIT and participation in NeHII. NeHII has found the initial subscription fees which cover the implementation costs to be a barrier for many organizations, particularly smaller institutions that are undercapitalized relative to their larger counterparts. In addition to the initial connectivity charges, organizations bear additional technical and administrative costs for: (1) configuring their internal systems to interface with HIE services, (2) reviewing the privacy and legal requirements for connectivity, and (3) training of staff to access and effectively utilize the new services.

As connectivity to the statewide HIE is critical to meeting DHHS' long-term vision, DHHS has submitted an IAPD including funding requested to accelerate high-value Medicaid providers' Use of HIE Services as a HIE Connectivity Direct Accelerant / Onboarding Program. The program will offer a targeted, time-limited payment to support the HIE costs for onboarding high-priority Medicaid providers to connect with and utilize NeHII's statewide HIE network in order to meet the meaningful use requirements of MIP. In order to participate in the program, providers will have to meet the following requirements:

- Eligible for MIP.
- An installed certified EHR system.
- Sign a participation agreement with NeHII for access to NeHII's statewide HIE network.
- Maintain HIE usage for 12 months after connectivity to the NeHII network.

DHHS is also exploring opportunities to begin utilizing information and services available through the statewide HIE to aid in administering the Medicaid and public health programs. DHHS included funding in the submitted IAPD to cover costs associated with the following efforts:

- Immunization Gateway – Required for tracking decreasing inventory at the State Immunization Registry (NESIIS) for the Vaccines for Children program. Without the ability to have immunizations from the Immunization Gateway decrease inventory automatically, the clinic/hospital must manually enter information into the NESIIS system patient by patient. By allowing NeHII to send the information electronically through the Immunization Gateway, the manual entries are eliminated and the count of remaining vaccines is accurate and available real time.
- Syndromic Surveillance - NeHII will collect syndromic surveillance data from hospitals and submit the information through an interface to DPH. DPH utilizes NEDSS to track disease patterns and coordinate responses to outbreaks in the State of Nebraska. Having this data submitted through NeHII will streamline the interface process which is expected to result in an increase of data submission. Currently, only two providers in Nebraska interface this data to public health.
- Electronic Lab Reporting - DPH intends to connect to NeHII to collect lab data. DPH does not currently have the ability to accept electronic lab reporting. Once implemented, NeHII will collect the lab data and submit the lab data through an interface to DPH.
- Open Access – Open Access will provide the ability for NeHII to accept and store Continuity of Care Documents (CCDs) received from participants in a parse-able format which allows for display and retrieval. Open Access will also provide the ability for a NeHII participant to display a CCD constructed from patient information collected across multiple sources, thus "community-wide".

3.3.2 MMIS Modernization

DHHS will be modernizing the MMIS to meet the future business needs of the Medicaid program.

The current DHHS MMIS system is approaching the end of its useful life. The foundation for the structure of the current MMIS technical architecture was developed in 1973 and became fully operational and certified in 1978. DHHS is currently in the process of planning for the modernization. The complete set of capabilities, and approach to obtaining them, are not yet determined at this juncture. However, DHHS expects that the following goals will be supported by this effort:

- Provide timely and accurate adjudication of Medicaid claims;
- Improve the efficiency and cost effectiveness of the Medicaid program;
- Improve communication between information systems;
- Improve the quality of, and access to, information leading to improved and informed decision making;
- Raise the MITA Maturity Level and align with MITA standards and conditions; and
- Improve information technology systems for increased flexibility and adaptability and increase responsiveness to needs within the DHHS business workflow.

3.3.3 Broadband Initiatives

In the State of Nebraska, broadband Internet access is generally available across the State; however, coverage is lacking in some rural areas. The vision for Nebraska is that broadband access will be readily available to providers regardless of geographic location. DHHS is not actively involved in the governance or funding of these initiatives. However, Medicaid enrolled providers, and therefore patients, will benefit.

3.4 MIP Administration and Oversight

Section 5 contains significant detail on the vision for administration of the incentive program. Providers will communicate attestation and meaningful use information through a convenient web portal. DHHS may consider the value proposition of interfacing with stakeholders at a future date.

3.5 Governance

Nebraska has established the necessary legal, strategic, and tactical governance to support the HIT initiatives for the To-Be vision. No further laws or governance needs to be established. The current authority model described in Section 2 As-Is Environment of this document is expected to continue as the future governance model.

4 Roadmap

As referenced in Section 3, DHHS does not anticipate that the long-term vision will be accomplished over the next five years. Provider adoption is critical to the eventual ability of DHHS to utilize the information for quality measures and care management. Without substantial adoption, the information is incomplete and not useful for these purposes. This section includes a sub-section on initiatives and measures.

4.1 Initiatives

DHHS has a table-based graphical representation of the roadmap of activities that can be performed to progress toward the long-term vision. Several of the initiatives are dependent upon funding being made available to support the initiatives. The initiatives are organized by the goals as listed in Section 3.

- Improve the efficiency of the administration of MIP.
- Pursue initiatives that encourage the adoption of certified EHR technology.
- Promote meaningful use of HIT, health care quality, and the exchange of health information
- Support the geographical and functional expansion of health information exchange capabilities.

Supported Goal(s)	Initiative	Calendar Year(s)
• Improve the efficiency of the administration of MIP. • Pursue initiatives that encourage the adoption of certified EHR technology.	Implement a new MIP administrative solution that automates existing manual processes and provides a user-friendly web-portal for provider.	2014
• Support the geographical and functional expansion of health information exchange capabilities. • Promote meaningful use of HIT, health care quality, and the exchange of health information.	Implement Immunization Gateway functionality within NeHII.	2015

Supported Goal(s)	Initiative	Calendar Year(s)
• Support the geographical and functional expansion of health information exchange capabilities. • Promote meaningful use of HIT, health care quality, and the exchange of health information.	Implement the HIE Connectivity Direct Accelerant / Onboarding Program to increase HIE connectivity of eligible hospitals and providers.	2015
• Support the geographical and functional expansion of health information exchange capabilities. • Promote meaningful use of HIT, health care quality, and the exchange of health information.	Implement Syndromic Surveillance interface between NeHII and DPH to improve data collection on disease patterns.	2015
• Support the geographical and functional expansion of health information exchange capabilities. • Promote meaningful use of HIT, health care quality, and the exchange of health information.	Implement Electronic Lab Reporting interface between NeHII and DPH to improve lab reporting data collection.	2015
• Support the geographical and functional expansion of health information exchange capabilities. • Promote meaningful use of HIT, health care quality, and the exchange of health information.	Implement Open Access functionality to accept, store, and display CCDs.	2015
• Pursue initiatives that encourage the adoption of certified EHR technology.	Implement the capability to support Meaningful Use Stage 3 Measures.	TBD

Supported Goal(s)	Initiative	Calendar Year(s)
• Promote meaningful use of HIT, health care quality, and the exchange of health information.	Refine quality measures and information needs for care management.	2015 - 2016
• Improve the efficiency of the administration of MIP. • Pursue initiatives that encourage the adoption of certified EHR technology. • Promote meaningful use of HIT, health care quality, and the exchange of health information. • Support the geographical and functional expansion of health information exchange capabilities.	Evaluate progress on provider adoption and assess next logical steps.	2017

4.2 Measures

DHHS has established measures for progress that are also critical to the DHHS long term plan. As referenced, provider adoption of EHRs is important however, accomplishing the long-term goal of connectivity to the state-wide exchange is critical. DHHS' established measures are in place to monitor this progress towards the ultimate goal of state-wide exchange.

4.2.1 MIP Measures

DHHS is monitoring the number of eligible providers and hospitals participating in the MIP as well as the volume continuing from the first year incentive into subsequent stages. As referenced earlier in the document, DHHS has seen great success in program participation. In 2011, DHHS had originally anticipated and set the benchmarks of 600 providers and 50 hospitals participating during the lifetime of the program.

In the first program year, 484 EPs qualified for a Medicaid incentive payment. 54% of the EPs returned for a second year payment in 2013. The current statistics include 596 unique EPs participating in MIP. Of the 90 hospitals in Nebraska, only six are not currently participating in either the Medicare or Medicaid EHR Incentive Program. Eleven dually-eligible hospitals are

currently participating only in the Medicare EHR Incentive Program primarily because they did not meet the 10% Medicaid patient volume requirement. 76% of those who received a Medicaid EHR Incentive payment in 2012 returned for a 2013 payment.

4.2.2 Health Insurance Exchange Connectivity Measures

Over 1606 representing providers and 20 of Nebraska's hospitals are currently connected to the state-wide health information exchange. DHHS expects significant increases in the connection rate of Medicaid providers upon implementation of the HIE Connectivity Accelerant / Onboarding Program. The table below includes quarterly connectivity expectations.

Category of Medicaid Provider	
	FFY15
Eligible Hospitals	17
Eligible Providers	174

5 Medicaid EHR Incentive Program Implementation, Administration, and Oversight

5.1 Introduction

The goal of the Nebraska MIP is to provide incentive payments to providers who meet the established criteria in furtherance of the national goal of meaningful use of EHR technology. This section of the SMHP contains the approach to implementation and ongoing administration of MIP. NE Medicaid is in the process of implementing a new system to support the MIP by the end of 2014. At the time of this update, the manual process is being used, but we have updated the document with the expected automated process that will be in place after implementation due the close proximity of the implementation date.

Nebraska Medicaid recognizes its responsibility for tracking of funds associated with the administration of the MIP program and has established charge codes to ensure that associated costs are able to be appropriately tracked for MIP activity. Administrative costs and incentive payment costs are tracked separately.

5.2 Implementation

While MIP has been well supported by the existing manual process, MLTC has contracted with MAXIMUS Human Services, Inc., referred to as the vendor throughout this document, to implement their existing, custom-off-the-shelf (COTS) solution to support Nebraska's MIP. By adopting an existing solution, Nebraska Medicaid benefits from significant savings and a shortened implementation schedule due to leveraging existing functionality and infrastructure. The existing functionality in the system will be configured to meet Nebraska's administrative needs for MIP which is provided in the Business Process Administration sub-section. The system will be hosted by the vendor, but the program will continue to be administered by state staff, referred to as MIP staff in this document.

5.2.1 Requirements Validation and Gap Analysis

A Requirements Validation and Gap Analysis has been completed for the implementation. While MIP is governed by specific CMS regulations, the actual implementation of the program has variance from state to state to support differences in operational structure, provider populations and support systems.

During the Requirements Validation, the vendor proposed solution was compared to Nebraska's MIP requirements to identify any gaps between the proposed solution and the requirements. This process identified configuration changes and system enhancements which were required to meet the requirements. The requirements and gap analysis processes were divided by functional area.

Each functional area began with a series of joint gap analysis sessions with participation from Nebraska business and technical staff and the vendor's project team.

During the sessions, the consolidated team assessed and reviewed the existing MIP Solution functionality against the requirements in the RFP. The walkthroughs resulted in the identification of a set of gaps in the existing solution that were addressed in the System Configuration and Enhancements deliverable.

5.2.2 System Configuration and Enhancements

The approach to system configuration and enhancement is based on an incremental build methodology based upon iterative configuration, meaning that requirements and solutions evolve through collaboration between the business subject matter experts and the development team. Results of the development effort are presented to the users as soon as they are complete rather than at the end of the entire configuration phase. The iterative approach enables the business staff to quickly see the results of the Requirements Validation and Gap Analysis activities. It also facilitates spending more time on testing rather than development and documentation.

In addition to the configuration and enhancement of the solution, interface configuration and enhancement must take place in order to facilitate the business process. The chosen solution uses an Open Interfaces framework that supports multi-channel data exchanges. The solution has already established and tested the interface with the NLR for provider registration and payment information and ONC for validation of certified EHR technology. Utilizing the same solution and existing interfaces significantly reduces the risk for interface issues with the NLR or ONC CHPL web service.

The framework also supports state specific interfaces that are being implemented as referenced below. DHHS expects that system changes to the reference existing state systems will expedite the processing of providers' payments through the MIP.

- Inbound and outbound interface to the state's financial system, Enterprise One. The outbound interface file will contain payment information for payment to be issued to providers. The inbound interface file will contain information related to the payment clearing the State's bank account.

- An inbound interface will be established with the MMIS identifying Medicaid eligibility, licensing, and type for providers who have applied for an incentive payment.

In conjunction with the configuration and enhancement work, unit testing is taking place according to the Test Execution Plan. The vendor will complete unit testing to ensure that the system functions correctly and that each modification is traceable to an associated requirement. As with most development projects, the individual developers have primary responsibility for successful

unit testing. The unit testing approach used will depend on the module and the tool used to create it.

5.2.3 System and Acceptance Testing

Testing is a critical aspect of the project and the ability for the system to support the administration of the program. Testing requires a systematic approach to validating features and functionality as well as finding, documenting, correcting, and re-testing defects. The vendor will conduct system testing to ensure they have met the agreed upon specifications finalized during Requirements Validation as well as supporting the MIP staff user acceptance testing so the solution can be deployed into production.

The vendor will utilize the Requirements Traceability Matrix and Gap Analysis to associate and track requirements and test cases to application programs or components to trigger any required retesting when a program or component is modified. Through this testing combination, they will test all discrete and related components of the MIP solution, including online pages, business edits, workflow, communications, and conversion. The system test cases and resulting test execution will ensure that the MIP solution is thoroughly tested and successfully interacts with data exchange partners. The testing approach will validate that all software components meet the functional and technical requirements as well as meeting associated performance requirements.

All “bugs” are documented and tracked in a Bugzilla tracking tool to ensure all reported items are accounted. The tool also allows reports to be generated and release notes to be provided when a release is approved for production. As defects are uncovered and reported, the vendor development staff will review the submitted documentation and determine what components require remediation. Defects are assigned to the development staff that is responsible for the remediation of the software or data correction based on the priority rating of the defect. Regression testing is performed based on the potential impact of the software changes. Tested fixes will be migrated to production.

As part of the approach to UAT, a production-like environment will be set up. MIP staff will perform UAT simulating production activities of each role available; eligible providers, eligible hospitals, review worker, payment processing, audit, and appeals.

5.2.4 Training and Knowledge Transfer

The vendor has existing training material available for the base product that will be modified as necessary to address the needs for MIP Staff. The training materials and overall solution is extremely user friendly. Training will focus on two base populations, providers and MIP staff.

Providers will receive communications through provider bulletins and updates posted to the Medicaid MIP web-site. We do not anticipate that formal training sessions will be necessary due

to the ease of use of the solution and how it guides a provider through the process. A complete online user manual will help support providers as well as MIP staff.

MIP staff will receive training prior to UAT testing. This type of training enables end users to begin using the system while the training knowledge is fresh in their minds. In addition to the user manual, formal training sessions will be scheduled with opportunity for the workers to perform functions within the system.

5.2.5 Implementation Support

System implementation marks the movement from system readiness to production operation. An Implementation Plan describes the approach that will be used to roll out the MIP Solution in the production environment including the strategy that will be undertaken to confirm that all pre-implementation activities have been completed and converted to the new system.

Following the successful completion of acceptance testing, implementation activities will progress according to the implementation plan. Operational readiness review is the final task required for the system to be approved and moved to production. It is a conglomeration of all preparation tasks and serves as a final check to ensure that the application, system configurations, user setups, and operational readiness are all complete. It also ensures that the organization is ready for production including the successful training of the staff to use the new system. As the operational readiness reviews are finalized, the results will be documented in the Operational Readiness Report, which includes the results of testing, status of interfaces, and an assessment of the final readiness of the solution.

5.2.6 Post Implementation Support

The vendor will prepare a Maintenance and Support Plan that will provide the details of how they will staff technical business resources and provide maintenance and support for the operational solution for the life of the project. Each component of the solution will be specified along with a responsibility matrix that shows the level of support, the procedures for reporting issues and the timeframes for response. The plan will also include escalation procedures and the process for reporting and correcting emergency issues.

The Maintenance and Support Plan will contain all of the details required to support the application including making changes and correcting defects, supporting telecommunications and the hosting environment, and detailed aspects of the operational environment. It will also address how enhancements will be handled. The existing solution contains functionality to support the program implementation including the Stage 1 and 2 meaningful use requirements. The vendor has committed to ensuring MIP staff receives any updates required to meet attestation needs for future stages of meaningful use or other changes required by CMS to support the program.

5.3 Business Process Administration

The MIP Solution is a Web-based application that supports all functions necessary to administer MIP. The solution is scalable, efficient, and cost effective. The graphic below illustrates the high level process steps.

5.3.1 Registration

The first step in receiving EHR incentive payments requires the provider to register with the National Level Repository (NLR). The NLR is a federal database that verifies basic provider

information prior to notifying State Medicaid programs of a provider's intent to participate in the Medicaid Incentive Program.

The NLR provides a daily batch feed (B6 interface) of new eligible professionals (EP) and eligible hospitals (EH) that have signed up for provider incentive payments as well as updated or cancelled registrations. The system uses the information from the B6 interface batch file to create workflows to begin the state registration and attestation process. The MIP solution will proactively send an email notification to the email address received on the B6 to instruct EPs and EHs regarding the state registration process.

Registration is a two-step authentication process. The provider must be able to provide their NPI, Tax ID and the CMS Registration Number received when registering with the NLR thus providing validation that the registrant is the provider and the provider has successfully registered with the NLR. Any user unable to provide these credentials cannot register.

Once these credentials are validated against the B6 interface files received from the NLR, the user is allowed to complete the registration process and create a user ID and password. A secret question must be answered to allow for self-service reset of passwords. The system then performs one additional validation step in the registration process. The system sends an email to the address received in the B6 interface file and the account remains inactive until the provider clicks a link embedded in the email to activate the account. This ensures the provider has access to the email account registered with NLR and that the email address is valid and can receive notifications from our system.

5.3.2 Attestation

The new solution provides the ability for providers to attest to Adopting, Implementing, or Upgrading (AIU) or Meaningful Use (MU) of an electronic health records system through a web-based portal. The solution gives the provider the tools needed to attest to AIU and MU criteria and allow them to upload supporting documentation as necessary.

Medicaid providers do not need to meet meaningful use criteria in the first participation year if the provider is attesting to adopting, implementing, or upgrading to certified EHR technology. However, meaningful use criteria must be met in subsequent years.

- Adoption –A signed purchase order or signed EHR vendor contract
- Implementation – Contract with REC (prior to February, 2014) or other entity with whom implementation exercises are planned, documented implementation work plan as well as an EHR vendor contractual arrangement
- Upgrading – Signed EHR vendor contract and signed vendor letter

Providers who enter the program under AIU must attest to meeting AIU requirements. The subsequent year would then be the first meaningful use reporting period and is a consecutive 90-

day period in the calendar year for which they are attesting. Eligible professionals can attest to either AIU or MU for the first year of participation and must attest to MU in the second and subsequent years of participation. Providers attesting for an incentive payment must attest to meeting the required threshold for Medicaid patient encounters. DHHS has published the calculations for eligible professionals and hospitals on the MIP website:

http://dhhs.ne.gov/medicaid/Pages/med_ehr.aspx

The MIP system includes a set of questions that providers must answer for AIU in order to ensure eligibility. In subsequent years, providers must also attest to these criteria in order to ensure they continue to meet the program requirements. These questions appear on different web pages by the type of data and guide the provider through the attestation process. Some questions are created dynamically based upon cross edits built into the system thus, providers and the MIP staff that reviews the attestation are not subject to questions that do not pertain to them. Where necessary, the system will automatically ask for additional detail from the provider. For example, if a provider indicates that she has Medicaid patients from other states the system will prompt the provider for specific counts of patient encounters and their individual Medicaid number from that state. If the provider type is PA, the system enforces that they are employed in an FQHC or RHC and must upload supporting documentation that they are the lead provider.

At every step of the process, the system allows the provider to upload any required documentation directly from the Web site and makes the uploaded documents available for State review.

During the attestation process, the system automatically validates the EHR technology's certification number received from the NLR on the B6 interface or entered on the provider's attestation through the MIP portal against the ONC Certified HIT Product List (CHPL) database.

The system guides providers through a series of questions and the uploading of documents in support of the provider's attestation of AIU or MU. The first series of questions relate to Medicaid program participation, demographic and state specific information that was not included in the data received from the NLR. This information is used to validate eligibility for incentive payments and as described.

Next, the provider attests to EHR questions in which they declare the EHR stage for which they are applying – AIU or MU. If the EHR certification number was not included at the NLR, the system notifies the provider to add it and does not allow the attestation submitted unless there is a valid certification number. In addition, to ensure the contract matches the EHR Certification number, the provider is also required to input a description of the system. Providers are also required to upload supporting documentation for the attestation year and when attesting for subsequent years.

The final step of the AIU attestation is to have the provider attest to patient volume. The system uses the information entered by the provider to calculate patient volume and to determine if the

provider met the minimum thresholds to be eligible for an incentive payment. Providers attesting only for AIU are allowed to continue to the submission screens. Providers attesting for MU must also complete the MU information. Business logic is embedded into the screen to automatically determine to which stage the provider should be attesting.

Providers are able to view the status of their attestation through the online portal.

5.3.3 Meaningful Use Tracking

Nebraska began accepting MU Stage 1 attestations on 1/1/2013. Providers must be in Stage 1 for two years before going to Stage 2. Stage 2 attestations will start 1/1/2015.

The functions required to support meaningful use need to not only be reflective of the currently defined requirements for meaningful use, they must also support the new requirements that CMS will define for future years as more comprehensive meaningful use criteria are released.

- EPs attesting to meeting the measures and objectives for meaningful use for the first time must use any continuous 90-day period within the calendar year for which they seek an incentive payment. For subsequent payment years, the EHR reporting period is the full calendar year for which a payment is sought.
- EHs attesting to meeting the measures and objectives for meaningful use for the first time must use any continuous 90-day period within the federal fiscal year for which they seek an incentive payment. For subsequent payment years, the EHR reporting period is the full federal fiscal year for which a payment is sought.
- To facilitate the implementation of Stage 2 CMS has determined that all providers attesting for 2014 will use a 90-day EHR reporting period

The MU functionality within the MIP Solution is designed to support not only the defined requirements for stages 1and 2, but also provide the structure for implementing new MU and clinical measure functions as they are defined by CMS. The key is to allow providers the ability to select the core and menu measures they will be using to track MU compliance and create a dynamic list of questions based on the selections. The use of this functionality will simplify the reporting process for providers since they will only see the questions they selected and they can utilize their EHR systems to provide the required verification documents.

All data since DHHS launched MIP in 2012 was converted to the new MIP system. The system is able to track the provider in the appropriate program year and payment year as well as the EHR stage. This ensures EPs cannot receive more than six payments and EHs cannot receive more than three payments through the course of the program.

The system validates that EPs and EHs must initially attest in 2016 or before to be able to participate in this program. All payments made to providers in MIP will end in 2021.

5.3.3.1 MU Questions

The MU attestation process begins with the provider selecting to attest to the Meaningful Use Core Set Questions screens. The screen presents a series of general questions including the EHR Reporting Period and number of unique patients whose data is in the certified EHR period. Following the general questions, the screen displays all of the Core Set questions required by CMS. Business logic is embedded into the system to ensure the provider meets the thresholds for each measure. The system will generate an error message to inform the provider if the response to any measure does not meet the required threshold. Providers must meet or exceed the thresholds for each measure before the system allows them to submit their attestation.

The process for attesting to the Menu Set measures begins with the system presenting the provider the list of all menu set questions. This list is dynamically created; it will display the Menu Set questions that are appropriate for the stage to which the provider is attesting. The system will also ensure that the provider selects the minimum number of Menu Set questions required to attest for each stage.

After the provider selects their questions, the screen will create the actual question screen displaying the objectives/measures selected by the provider. As with the Core Set questions, system logic ensures all requested information is entered and that the answers meet or exceed CMS thresholds.

To complete their attestation for Meaningful Use the provider must attest to the Clinical Quality Measures (CQMs) as specified by CMS.

Providers are encouraged to select CQMs that are relevant to their scope of practice. The provider may also select a list of recommended CQMs for Adult or Pediatric patient populations. The system presents a selection screen to allow the EP to select the option for the Adult patient, Pediatric patient population, or to manually select the CQMs from the complete list. System edits prevent an attestation from being submitted unless it has the required number of CQMs as well as the necessary domains as required by CMS.

5.3.4 Attestation Review

Once the provider has completed the attestations questions, the system allows for submission of the electronic attestation. A series of legal statements is provided and the provider agrees they are completing the application according to applicable state and federal regulations.

Once the provider agrees to the legal statements, the system initiates a work queue item for the MIP staff to validate the information provided. The attestations can be viewed in any status. MIP staff has the ability to choose to view their entire work queue or sort by Provider Name, NPI, Provider Type, or Status. Upon selecting to review a provider, the system generates a review screen

that identifies the provider and gives pertinent demographic information from the B6 interface file along with links to review each of the attestation criteria.

The screen allows the review of all attested questions as well as uploaded documents. MIP staff reviews each of the attestation criteria and elects to approve the attestation, deny it, or return it to the provider. Once the provider addresses the return reason, the worker can then resume the review.

While significant functionality has been automated, some manual processes still exist. The worker reviews the provider attestation and validates the following information:

- Medicaid patient encounters are validated by MIP staff by running a report from the state claims data warehouse. The worker validates that the provider submitted Medicaid encounter volume is within 10% of the volume contained within the claims data warehouse. The worker also validates that the provider meets the Medicaid volume percentage threshold. If the volume is outside of this parameter, the provider is requested to supply the detailed list of the Medicaid encounters to determine if the correct criteria was selected. If out of state patient volume was included, MIP staff will attempt to obtain verification of volume from the appropriate state Medicaid agency.
- MIP staff validate that providers are not considered hospital-based by running data warehouse reports to ensure that 90% or more of the encounters were not at a place of service 21 or 23. If the 90% is not met, MIP staff contact the provider and require the provider to submit information to support that the provider funded the acquisition, implementation and maintenance of CEHRT including supporting hardware and any interfaces necessary to meet MU without reimbursement from an EH; and uses their own CEHRT in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT).
- The average length of stay for EHs must be 25 days or less and is validated by MIP staff by determining the total inpatient bed days divided by the total discharges. The CCNs for EHs must be between 0001-0879 (acute care), 1300-1399(critical access), and 3300-3399 (children). Both children's hospitals in Nebraska have CCNs. The CCN ranges that were submitted on the B6 are validated by the system to ensure they meet within these requirements.
- The data warehouse is also used to validate providers in an FQHC/RHC meet the practice predominantly requirements if they are claiming needy patients in addition to Medicaid patient volume.
- If the provider type is PA, the system will require the provider to upload supporting documentation. MIP staff will validate that the FQHC/RHC is led by the PA by considering the following:
    - Is the PA's name on the relevant licenses, leases, etc.?
    - Does the PA sign off on the practice's policies and procedures?
    - Does the PA do performance reviews for the other employees?

    - Does the PA set quality goals for the practice?
- Verify that the verification documents support meaningful use as required.

The MMIS Interface will validate:

- The provider is enrolled in Medicaid as an M.D., D.O., Nurse Practitioner, Certified Nurse Midwife, PA, or Dentist.
- The provider is an actively enrolled provider of NE Medicaid, not currently sanctioned or deceased.
- The provider's license number from the attestation matches the one validated by provider enrollment.
- If the attestation indicates the provider is a pediatrician, the provider's specialty and taxonomy will be checked to validate the provider is a pediatrician
- If the provider has voluntarily reassigned their payment to a payee, the payee relationship will be validated by the MMIS
- If a provider claimed group or individual reporting, all members within that group used the same methodology

The MIP system will identify whether the MMIS interface was able to validate the information. Anything not validated by the MMIS interface will require MIP staff to complete follow up.

Once the attestation review is completed, the MIP staff finalizes the attestation. The attestation then goes to a second MIP staff to review. The same MIP staff cannot process an attestation through to payment. This ensures payment accuracy. If the second MIP staff approves the provider's eligibility, the system processes the attestation and calculates the payment amount based on program year and provider type. This also generates a B7 interface to the NLR setting the provider to active status. The system transmits the calculated payment information to the NLR via the D16 request interface to check for duplicate payments and federal sanctions before making a payment. A D16 response from the NLR identifies any processed or pending payments from other states as well as any exclusions. Exclusions will be noted on the payment record and the provider will be notified if there is a problem with the payment along with the reason.

In the case of a denial, the system will allow the MIP staff to select the reason for the denial from a drop-down window. The system creates a B7 denial transaction and generates an email notification that includes dynamically created messages specific to the reason for denial. The system automatically sends the email to the provider and informs the provider of their option to initiate the appeals process, if they so desire. All attempts to resolve eligibility issues are made with the provider prior to denying. Final approval and denial is completed only in the second review process.

5.3.5 Payment Processing

The system will automatically calculate the incentive payment amount due to the eligible provider based on federal requirements ($21,250 for the first year and $8,500 for subsequent years) up to a maximum of six years. Pediatrician payments will be reduced to 2/3 of the payment if the Medicaid patient volume is between 20-29%.

The system will automatically calculate the EH payment based on the payment rules. Due to the high cost of hospital software and to encourage the early adoption of the EHR technology in hospitals, Nebraska makes the payment over the minimum three-year period and at the maximum allowable percentages in each year which the EH qualifies for payment: Year 1 = 50 percent, Year 2 = 40 percent, Year 3 = 10 percent. Hospitals that began participation in 2013 and later, use the most recent continuous 12 month period for which data is available prior to the payment year. Hospitals that began participation prior to the Stage 2 rule will not have to adjust previous calculations. Previously, Medicaid EHR calculated the base year using a 12 month period ending in the FFY before the hospital fiscal year that serves as the first payment year.

Provider payment years do not have to be consecutive. While payment to eligible providers is relatively standard and not complex, payments to eligible hospitals are automatically calculated based on information gathered through cost reporting. All payment processing calculation rules are published on the web-site:

http://dhhs.ne.gov/medicaid/Pages/med_ehr.aspx

Payment processing with the MIP solution will initiate payment to the Enterprise One statewide financial system after all editing logic has passed, the application has been approved based on the review, an approval D16 response has been received from CMS, and the system has verified that an existing payment is not present for the program year. The payment processing will be daily.

After payment has been initiated in the financial system, the system tracks the status of the payment as well as the 45-days from the D16 to ensure payments are processed timely. A response file will be sent from the Enterprise One state financial system to the MIP system when the payment has been created. The MIP system will generate the D18 to the NLR when the payment has been made.

5.3.5.1 Adjustment Processing

Nebraska Medicaid will recoup any payments made in error. Adjustment processing is another core function included in the MIP Solution. This functionality allows payment adjustments to EPs and EHs based on changing information such as a post-pay audit, or the results of a successful appeal.

5.3.6 Audit and Oversight

DHHS has drafted an audit plan to support program oversight. The audit plan details the methods DHHS is using to avoid making improper payments and recovering erroneous payments through the EHR Incentive Program to Eligible Professionals (EPs) and Eligible Hospitals (EHs).

Suspected fraud or abuse may be detected at any point during an audit or review process. As described in the Attestation Review step, DHHS MIP Program staff are conducting extensive pre-payment verification which DHHS expects will minimize fraud and abuse and prevent incorrect payments before the payment is issued. If potential fraud or abuse is discovered during the pre-payment attestation review, the potential case will be forwarded to Program Integrity staff.

DHHS Program Integrity staff are responsible for conducting post-payment audits and following up on potential fraud and abuse cases. Post-payment audits are triggered based on multiple risk factors as well as through random sampling. The risk factors have purposely been omitted from this document. The results of audit findings will be stored in the MIP solution and quarterly information will be submitted to CMS including the number of audits conducted, outcome of those audits, instances of fraud/waste/abuse, and the number and amount of incentive payments recovered. When a case has reached the threshold of fraud, the case is referred to the Medicaid Fraud Control Unit.

5.3.7 Appeals

Per CMS guidelines, eligible professionals and hospitals have the right to appeal the State's decisions regarding incentive payments, incentive payment amounts, eligibility determination, and demonstration of AIU and/or MU.

The provider can file an appeal through the online portal if the attestation is denied or there is a dispute of the amount of the EHR Incentive payment made. The following is required to file an appeal:

- A statement that he/she is appealing the state's action;
- Identification of the exact basis for the appeal;
- A statement as to why the provider believes the State has made an error; and
- Providers may optionally submit any additional documentation that supports the appeal for review by MIP staff.

The system will automatically send a confirmation email to the provider acknowledging the receipt of the appeal. All communications will be logged in the provider's contact/note log. The system will place any appeal received into the Appeals work queue. An internal email will be generated to alert the appropriate MIP staff that an appeal has been filed so the appeal can be review and resolved, if possible.

The appeal will follow the formal process outlined in Nebraska Statute Title 471 Chapter 2 Section 2-003 and Nebraska Statute Title 465 Chapter 6. An E8 interface will be generated to the NLR for appeals.

5.3.8 Reporting

Effective and timely reporting is necessary for the management of the MIP operations and program. The new solution uses a combination of standard reports, dashboard reporting and online data to support the administration of the program. These reporting processes provide all required information about the program and individual registrations. While all reporting functions are available online, the solution allows creation in various formats including Microsoft Word and Excel and Adobe PDF. Examples of the reports that will be used to manage the operations and program include:

- **Queue Aging Report** –Provides summary information on the applications in each work queue. The report can be sorted in numerous ways.
- **Transactions Reports** - this report keeps track of the various inbound and outbound NLR transactions and error files that are received. It is a secondary check to ensure all attestation records have been processed. Currently this report is used to ensure all incoming files have been processed and no attestations have been missed by the CMS system.
- **Payment Summary Report** - this report is used to show the status of payments in the system. It includes applications where D-16 transactions have been sent to CMS and are pending a response, those that have been sent to the financial system for processing, and those that have been paid. It is a powerful tool for ensuring that all payments are being processed, no attestations are pending at CMS, and the State financial system has processed all payments sent. It also gives a total of payments made by week and year.
- **Post-Pay Audit Report** – this report provides summary information across all types of audits. Information included in the report will include both pending and paid cases flagged for audit.
- **Meaningful Use Summary Reports –** this report allows the review of meaningful use data by provider. The system also contains summary reports that aggregate MU data by region or provider specialty. Additionally, the MU summary report screens contain an option for a consolidated report that combines a provider's responses to all the criteria for meaningful use (including general questions, Core Set, Menu Set, and Clinical Quality Measures, etc.) into a single report. The consolidated report is a powerful, efficient tool for reviewing a provider's eligibility for a meaningful use incentive payment.

In addition to the standard reports, the capability to ad-hoc reports also exists for analysis as needed as well as reporting needed for CMS annual and quarterly reports.

5.4 Managed Care Payments

Nebraska will disburse payments directly to the providers or their requested assigned payee. Managed care entities will not be used to disburse incentive payments eliminating the need to calculate an impact to capitation rates.

5.5 Communication with Providers

DHHS has created and is executing to a communication plan in order to communicate with providers. DHHS has established several methods for communicating with providers. When new information becomes available that needs to be communicated, DHHS determines the most appropriate methods for communication. Within this sub-section, DHHS has included information on the methods of communication.

5.5.1 Web Page

Nebraska provides a Web page devoted to MIP that includes the following details:

1. Eligibility criteria;
2. Enrollment forms and instructions
3. Potential payout amounts;
4. Payment timelines;
5. Calculations examples;
6. How to apply;
7. Resources for more information;
8. Links to other pertinent Nebraska and CMS Web pages
9. Frequently asked questions.

5.5.2 E-mail

Alerts will be sent out as needed to EPs and EHs who subscribe to receive e-mails from a Web page subscriber list on the Web page. Additionally, the new MIP solution will utilize e-mails to inform providers of relevant information regarding their attestation status. The e-mails will be sent based on triggers in the MIP system. For example, an automated email will be created notifying the provider when they are found eligible or not eligible for the Medicaid incentives. The providers can check the status of their attestation at any time through the MIP portal.

5.5.3 Medicaid Provider Bulletins

Bulletins are available electronically for all EPs and EHs. All issued bulletins remain available for EPs and EHs to reference any time. Since EPs and EHs are already required to check these bulletins online, this is anticipated to be highly effective communication tool.

5.5.4 Provider Handbooks

Handbooks are provider-type specific, and therefore affected provider handbooks will be updated as necessary. This is also a highly effective method of communication because providers are required to stay current with items covered in their respective handbooks. These handbooks are found online.

5.5.5 Postal Mail

Hard copies of extremely important notifications will be mailed to all providers who are eligible for incentive payments. This delivery method will be used sparingly because of the cost.

5.5.6 Medicaid Inquiry Line

Providers access the Medicaid inquiry line for provider support; so providers will contact the line with incentive payment questions. Incentive questions will be directed to Nebraska Medicaid EHR Program staff.

5.5.7 Presentations and Workshops

Nebraska developed several slides show presentations which are posted on the website. Slide show presentations have also been given at various events in the past and will be used in the future as needed.

5.5.8 Professional Association Meetings

DHHS will develop and provide relevant EHR literature to associations and work with associations on the best ways to deliver materials to providers. The associations are responsible for delivering information to its members. This is an effective method to reach some providers and allows for the associations to provide feedback.

Appendix A Acronyms

Acronym	Phrase
AIU	adoption, implementation, or upgrade
AHRQ	United States Department of Health and Human Services Agency for Healthcare Research and Quality
ARRA	American Recovery and Reinvestment Act of 2009
CAH	critical access hospital
CCN	CMS Certification Number
CCD	Continuity of Care Document
CDC	Centers for Disease Control and Prevention
CEHRT	Certified Electronic Health Record Technology
CHPL	Certified Health IT Product List
CMS	Centers for Medicare and Medicaid Services
CQM	Clinical Quality Measures
DBH	State of Nebraska Division of Behavioral Health
DHHS	State of Nebraska Department of Health and Human Services
DPH	State of Nebraska Division of Public Health
eBHIN	Nebraska Electronic Behavioral Health Information Network
EDI	electronic data interchange
EH	eligible hospital
EHR	electronic health record
EMR	electronic medical record
EP	eligible professional
FQHC	federally qualified health center
FY	fiscal year
HIE	health information exchange
HIPAA	Health Information Portability and Accountability Act
HIT	health information technology

Acronym	Phrase
HITECH	Health Information Technology for Economic and Clinical Health
HRSA	United States Department of Health and Human Services' Health Resources and Services Administration
IAPD	Implementation Advance Planning Document
IHS	Indian Health Service
MIP	Medicaid EHR Incentive Program
MITA	Medicaid Information Technology Architecture
MLTC	Nebraska DHHS Division of Medicaid & Long-Term Care
MMIS	Medicaid Management Information System
MU	Meaningful Use
NEDSS	Nebraska Electronic Disease Surveillance System
NeHII	Nebraska Health Information Initiative
NESIIS	Nebraska State Immunization Information System
N-FOCUS	Nebraska Family Online Client User System
NITC	Nebraska Information Technology Commission
NLR	CMS National Level Repository
NPI	National Provider Identification
ONC	Office of the National Coordinator for Health Information Technology
PHINMS	Public Health Information Network Messaging System
REC	Regional Extension Center
RHC	rural health clinic
SENHIE	South East Nebraska Health Information Exchange
SLR	Nebraska State Level Repository
SMHP	State Medicaid Health Information Technology Plan
SSEDON	Syndromic Surveillance Event Detection of Nebraska
TCHS	Thayer County Health Services

Acronym	Phrase
TIN	Taxpayer Identification Number
UAT	User Acceptance Testing
VA	Veterans Administration
VA NWIHCS	Veterans Administration Nebraska-Western Iowa Health Care System
VistA	Veterans Health Information Systems and Technology Architecture
Wide River TEC	Wide River Technology Extension Center

Appendix B Glossary

Term	Definition
Adoption, Implementation, or Upgrade (AIU)	These terms are used by CMS as part of the eligibility criteria for EHR incentives. These terms reference the provider's adoption, implementation or upgrade of a certified EHR system.
American Recovery and Reinvestment Act (ARRA)	An economic stimulus package enacted by the 111th Congress in February 2009, commonly referred to as the Stimulus or The Recovery Act.
Children's Health Insurance Program (CHIP)	CHIP program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.
Critical Access Hospital (CAH)	A hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures.
Electronic Health Record (EHR)	An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.
Electronic Medical Record (EMR)	An electronic record of health-related information for an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.
Enterprise One	Nebraska's accounting and payment system which is used to make all payments issued by the State, including MMIS claims payments. The system utilizes Oracle's JD Edwards application.
e-prescribing	Practice in which drug prescriptions are entered into an automated data entry system (handheld, PC, or other), rather than handwriting them on paper. The prescriptions can then be printed for the patient or sent to a pharmacy via the Internet or other electronic means.
Health Information Exchange (HIE)	The electronic movement of health-related information among organizations according to nationally recognized standards.

Term	Definition
Health Information Technology (HIT)	The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision-making.
Indian Health Service	A part of the U.S. Public Health Service within the US Department of Health and Human Services, the Indian Health Service is responsible for providing federal health services to American Indians and Alaska Natives.
Interoperability	HIMSS' definition of interoperability is "ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities."
Meaningful Use	As defined by CMS in 42 CFR Part 495.
Medicaid Information Technology Architecture (MITA)	A federal, business-driven initiative that affects the Medicaid enterprise in all states by improving Medicaid program administration, via the establishment of national guidelines for processes and technologies. MITA is a common business and technology vision for state Medicaid organizations that supports the unique needs of each state.
Medicaid Management Information System (MMIS)	The MMIS is one of the primary repositories of provider information. MMIS capabilities will be leveraged to fulfill a range of functions, including the provision of data necessary to enable payment administration.
National Level Repository (NLR)	The NLR is the federal database that stores Medicaid and Medicare EHR Incentive Program data. This database supports MEIPRAS.
Nebraska Information Technology Commission (NITC)	The NITC is a nine-member, governor-appointed commission. Its mission is The mission of the Nebraska Information Technology Commission is to make the State of Nebraska's information technology infrastructure more accessible and responsive to the needs of its citizens, regardless of location, while making investments in government, education, health care and other services more efficient and cost effective.
Office of the National Coordinator for Health Information Technology (ONC)	ONC provides leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care and the ability of consumers to manage their care and safety.

Term	Definition
Portal	A website that offers a range of resources, such as email, chat boards, search engines, and content.
Provider	A provider is an individual or group of individuals who directly (primary care physicians, psychiatrists, nurses, surgeons, etc.) or indirectly (laboratories, radiology clinics, etc.) provide health care to patients. In the case of this SMHP and the EHR Incentive Program, Provider refers to both eligible professionals (EPs) and eligible hospitals (EHs).
Regional Extension Center (REC)	An organization that has received funding under the Health Information Technology for Economic and Clinical Health Act to assist primary care health care providers with the selection and implementation of electronic health record technology.
Stakeholder	A stakeholder is any organization or individual that has a stake in the exchange of health information, including health care providers, health plans, health care clearinghouses, regulatory agencies, associations, consumers, and technology vendors.
State Level Repository (SLR)	The SLR is the database supporting the Medicaid EHR Incentive Program administration. The SLR will capture state-collected data elements as part of the intake. The SLR will contain basic data elements that have been transferred from the NLR (e.g., National Provider Identifier (NPI); CMS Certification Number (CCN) for an EH; EP type; affiliation, etc.). The SLR will capture other relevant information from the EP/EH (e.g., email address; EP affiliation with a managed care organization) to establish eligibility for the EHR incentive program, including patient volume and attestation information.
Telehealth	Is the remote care delivery or monitoring between a healthcare provider and patient? There are two types of telehealth: phone monitoring (scheduled encounters via the telephone) and telemonitoring (collection and transmission of clinical data through electronic information processing technologies.
Telemedicine	Is a rapidly developing application of clinical medicine where medical information is transferred through interactive audiovisual media for the purpose of consulting, and sometimes remote medical procedures or examinations?

Appendix C SMHP Requirements Mapping

To ease the reader's review of the plan, DHHS has copied the SMHP Overview document produced by CMS and identified the area of the SMHP where the topic is addressed. DHHS has identified the sections at the most specificity available. However, in some instance, the topic is addressed throughout a document section which limited the specificity of the reference.

<table>
<tr><th colspan="2">State Medicaid HIT Plan (SMHP) Overview</th></tr>
<tr><td>PURPOSE:
The SMHP provides State Medicaid Agencies (SMAs) and CMS with a common understanding of the activities the SMA will be engaged in over the next 5 years relative to implementing Section 4201 Medicaid provisions of the American Recovery and Reinvestment Act (ARRA).

THIS IS A DRAFT, OPTIONAL TEMPLATE.</td><td>SCOPE: Section 4201 of the ARRA provides 90% FFP HIT Administrative match for three activities to be done under the direction of the SMA:

1. Administer the incentive payments to eligible professionals and hospitals;
2. Conduct adequate oversight of the program, including tracking meaningful use by providers; and
3. Pursue initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information.

We are particularly interested in how the States plan to go about making the provider incentive payments (100% FFP), how they will monitor them, and how the SMAs' plans will dovetail with other State-wide HIE planning initiatives and Regional Extension Centers supported by the Office of the National Coordinator for HIT (ONC) and other programs.

Please be sure to indicate in the SMHP what activities the SMA expects will be included in a HITECH Implementation-APD or a MMIS APD so that CMS can crosswalk the SMHPs to their corresponding funding request documents.

If a State has already begun work on their SMHP, they should consider how it lines up with the content in this draft template before submitting it to CMS for review.</td></tr>
<tr><td colspan="2">TIME FRAME:
The SMHP time horizon is five years, although States may discuss their plans beyond that, if appropriate. We understand States have a better understanding of their current, near-term needs and objectives, and that plans will change over time. For this reason, we will expect to receive annual updates, as well as as-needed updates, to keep CMS informed of the SMHP as it evolves, and States' ability to meet their targets over the next five years. We expect that States will want to revise their SMHPs over time, particularly for initiatives to encourage the adoption of certified EHR technology.</td></tr>
<tr><td colspan="2">REQUIRED VS. OPTIONAL CONTENT:
We recognize that not every element of the SMHP is of equal weight and priority-level in order to implement the EHR Incentive Program at the barebones minimum. We have flagged the questions which a State may choose to defer for a later iteration. For example, some States may not be ready to take on activities in 2011 to promote EHR adoption and HIE among Medicaid providers but are fully planning to be able to make EHR incentive payments to the right providers, under the correct circumstances in the first year of the program.</td></tr>
</table>

SECTION A: The State's "As-Is" HIT Landscape	
The State's "As-Is" HIT Landscape: This information should be a result of the environmental scan and assessment conducted with the CMS HIT P-APD funding; or was available to the SMA through other means (e.g. was part of the ONC HIE cooperative agreement planning and assessment activities or other HIT/E assessments.)	1. What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State's providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of provider? Does the SMA have data on EHR adoption by types of provider (e.g. children's hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)? RESPONSE: Addressed in Sections 2.1.1 and 2.1.2 2. To what extent does broadband internet access pose a challenge to HIT/E in the State's rural areas? Did the State receive any broadband grants? RESPONSE: Addressed in Section 2.3. 3. Does the State have Federally-Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe. RESPONSE: Addressed in Section 2.1.3. 4. Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe. RESPONSE: Addressed in Sections 2.1.5 and 2.1.6. 5. What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized? RESPONSE: Addressed in Section 2.1 6. Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc.) of these activities? RESPONSE: Addressed in Section 2.1. 7. Specifically, if there are health information exchange organizations in the State, what is their governance structure and is the SMA involved? ** How extensive is their geographic reach and scope of participation? RESPONSE: Addressed in Section 2.1.7 8. Please describe the role of the MMIS in the SMA's current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how. RESPONSE: Addressed in Sections 2.1.12 and 2.1.13. 9. What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use?

	RESPONSE: Addressed in Section 2.1. 10. Explain the SMA's relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive program. RESPONSE: Addressed in Section 2.1. 11. What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years? RESPONSE: Addressed in Sections 2.1.11 and 2.1.13. 12. Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe. RESPONSE: Addressed in Section 2.2. 13. Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe. RESPONSE: Addressed in Sections 2.1.3, 2.1.7, & 2.4. 14. What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)? RESPONSE: Addressed in Section 2.1.10. 15. If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant please include a brief description. RESPONSE: N/A
SECTION B: The State's "To-BE" Landscape	
The State's "To-Be" Landscape	1. Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible; e.g., the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc. RESPONSE: Addressed in Sections 2.1.1, 2.1.2, 3.1, and 3.2 2. *What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA's long term goals and objectives? Internet portals? Enterprise Services Bus? Master Patient Index? Record Locater Service? RESPONSE: Addressed in Section 3.3 and 3.4 3. How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)? RESPONSE: Addressed in Section 5. 4. Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA's HIT/E goals and objectives? While

	we do not expect the SMA to know the specific organizations will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies RESPONSE: Addressed in Sections 2 and 3.4. 5. What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology? RESPONSE: Addressed in Section 3.1 and 3.2. 6. ** If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption? RESPONSE: Addressed in Sections 2.1.3 and 3.2. 7. ** How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology? RESPONSE: Addressed in 3.2. 8. ** How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program? RESPONSE: Deferred. 9. If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.? RESPONSE: Addressed in Sections 2 and 3. 10. Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe. RESPONSE: Addressed in Section 3.4. Please include other issues that the SMA believes need to be addressed, institutions that will need to be present and interoperability arrangements that will need to exist in the next five years to achieve its goals. RESPONSE: Addressed in Sections 2 and 3. * This question may be deferred if the timing of the submission of the SMHP does not accord with when the long-term vision for the Medicaid IT system is decided. It would be helpful though to note if plans are known to include any of the listed functionalities/business processes. ** May be deferred.

SECTION C: Activities Necessary to Administer and Oversee the EHR Incentive Payment Program	
The State's Implementation Plan: Provide a description of the processes the SMA will employ to ensure that eligible professional and eligible hospital have met Federal and State statutory and regulatory requirements for the EHR Incentive Payments.	1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers? RESPONSE: Addressed in Section 5.3.4. 2. How will the SMA verify whether EPs are hospital-based or not? RESPONSE: Addressed in Section 5.3.4. 3. How will the SMA verify the overall content of provider attestations? RESPONSE: Addressed in Section 5.3.4. 4. How will the SMA communicate to its providers regarding their eligibility, payments, etc.? RESPONSE: Addressed in Section 5.5 5. What methodology will the SMA use to calculate patient volume? RESPONSE: Addressed in Section 5.3.2. 6. What data sources will the SMA use to verify patient volume for EPs and acute care hospitals? RESPONSE: Addressed in 5.3.4 7. How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement? RESPONSE: Addressed in 5.3.4. 8. How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers? RESPONSE: Addressed in 5.3.4. 9. How will the SMA verify meaningful use of certified electronic health record technology for providers' second participation years? RESPONSE: Addressed in Sections 5.3.3 and 5.3.4 10. Will the SMA be proposing any changes to the MU definition as permissible per rule-making? If so, please provide details on the expected benefit to the Medicaid population as well as how the SMA assessed the issue of additional provider reporting and financial burden. RESPONSE: DHHS does not propose any changes to the federal MU definition.

	11. How will the SMA verify providers' use of certified electronic health record technology? RESPONSE: Addressed in Section 5.3.4. 12. How will the SMA collect providers' meaningful use data, including the reporting of clinical quality measures? Does the State envision different approaches for the short-term and a different approach for the longer-term? RESPONSE: Addressed in Section 5.3.3. 13. * How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA? RESPONSE: Deferred. 14. What IT, fiscal and communication systems will be used to implement the EHR Incentive Program? RESPONSE: Addressed in Sections 5.1, 5.2, and 5.3. 15. What IT systems changes are needed by the SMA to implement the EHR Incentive Program? RESPONSE: Addressed in Sections 5.1, 5.2 and 5.3. 16. What is the SMA's IT timeframe for systems modifications? RESPONSE: Addressed in Section 5.1. 17. When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (NLR)? RESPONSE: Addressed in Sections 5.1 and 5.2. 18. What is the SMA's plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe to mainframe interface or another means)? RESPONSE: Addressed in Sections 5.2 and 5.3. 19. What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc.? RESPONSE: Addressed in Section 5.5. 20. Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD? RESPONSE: Addressed in Section 5.2.2. 21. What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program? RESPONSE: Addressed in Section 5.5

	22. What will the SMA establish as a provider appeal process relative to: a) the incentive payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement or upgrade and meaningful use certified EHR technology? RESPONSE: Addressed in Section 5.3.7. 23. What will be the process to assure that all Federal funding, both for the 100 percent incentive payments, as well as the 90 percent HIT Administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS FFP? RESPONSE: Addressed in Section 5.1. 24. What is the SMA's anticipated frequency for making the EHR Incentive payments (e.g. monthly, semi-monthly, etc.)? RESPONSE: Addressed in 5.3.5. 25. What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate? RESPONSE: Addressed in Sections 5.3.4 and 5.3.5. 26. What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designated by the state and approved by the US DHHS Secretary, are made only if participation in such a payment arrangement is voluntary by the EP and that no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption? RESPONSE: DHHS does not plan to designate an entity promoting the adoption of certified EHR technology. Therefore, no response is required. 27. What will be the process to assure that there are fiscal arrangements with providers to disburse incentive payments through Medicaid managed care plans does not exceed 105 percent of the capitation rate per 42 CFR Part 438.6, as well as a methodology for verifying such information? RESPONSE: Addressed in Section 5.4. 28. What will be the process to assure that all hospital calculations and EP payment incentives (including tracking EPs' 15% of the net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation? RESPONSE: Addressed in Sections 5.3.4 and 5.3.5. 29. What will be the role of existing SMA contractors in implementing the EHR Incentive Program – such as MMIS, PBM, fiscal agent, managed care contractors, etc.? RESPONSE: Addressed in Sections 5.2 and 5.4. 30. States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon:

	• The role of CMS (e.g. the development and support of the National Level Repository; provider outreach/help desk support) • The status/availability of certified EHR technology • The role, approved plans and status of the Regional Extension Centers • The role, approved plans and status of the HIE cooperative agreements • State-specific readiness factors RESPONSE: Addressed in Section 4. Initiatives and timelines are based on I-APD funding approval. *May be deferred
SECTION D: The State's Audit Strategy	
The State's Audit Strategy: Provide a description of the audit, controls and oversight strategy for the State's EHR Incentive Payment Program.	What will be the SMA's methods to be used to avoid making improper payments? (Timing, selection of which audit elements to examine pre or post-payment, use of proxy data, sampling, how the SMA will decide to focus audit efforts etc.): • Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment. RESPONSE: Addressed in Section 5.3.6. • How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY? RESPONSE: Addressed in Section 5.3.6. • Describe the actions the SMA will take when fraud and abuse is detected. RESPONSE: Addressed in Section 5.3.6. • Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe. RESPONSE: Addressed in Section 5.3.6. • Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?* (i.e. probe sampling; random sampling) RESPONSE: Addressed in Section 5.3.6. • **What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc.)?

	RESPONSE: Addressed in Section 5.3.6. • Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated? RESPONSE: Addressed in Section 5.3.6. * The sampling methodology part of this question may be deferred until the State has formulated a methodology based upon the size of their EHR incentive payment recipient universe. ** May be deferred
SECTION E: The State's HIT Roadmap	
The State's HIT Roadmap: Annual Measurable Targets Tied to Goals	1. *Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there. RESPONSE: Addressed in Section 4.1 2. What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type? RESPONSE: Addressed in Section 4.2 3. Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario. RESPONSE: Addressed in Section 4.2 4. Discuss annual benchmarks for audit and oversight activities. RESPONSE: Addressed in Section 4.2. CMS is looking for a strategic plan and the tactical steps that SMAs will be taking or will take successfully implement the EHR Incentive Program and its related HIT/E goals and objectives. We are specifically interested in those activities SMAs will be taking to make the incentive payments to its providers, and the steps they will use to monitor provider eligibility including meaningful use. We also are interested in the steps SMAs plan to take to support provider adoption of certified EHR technologies. We would like to see the SMA's plan for how to leverage existing infrastructure and/or build new infrastructure to foster HIE between Medicaid's trading partners within the State, with other States in the area where Medicaid clients also receive care, and with any Federal providers and/or partners. * Where the State is deferring some of its longer-term planning and benchmark development for HIT/E in order to focus on the immediate implementation needs around the EHR Incentive Program, please clearly note which areas are still under development in the SMA's HIT Roadmap and will be deferred.